 Administrative Office

Integrative Counseling and Psychological Services 1777 Axtell Dr., Suite 100, Troy, MI 48084

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**Insurance Details / Self Pay**

**Method of Payment Information Form**

|  |  |
| --- | --- |
| **Today’s Date** |  |
| **Client Name** |  |
| **Client Date of Birth** |  |
| **Client Gender** |  |
| **Client Address (House Number, Street, City and Zip Code)** |  |
| **Client Phone Number** |  |
| **Therapist Name / Credentials** |  |
| **Insurance Details OR Self Pay “Cash” Client**   |  |  | | --- | --- | | ***INSURANCE TYPE*** |  | | Employer |  | | Member / Enrollee ID# |  | | Group # |  | | Insurance Phone# (back of card) |  | | Subscriber Name and DOB  *If different from client* |  |  |  |  | | --- | --- | | ***CASH RATE*** per session |  | | |
| **Patient Profile Complete?** |  |
| **Any Out of Pocket Costs Explained to Client / Guardian?** |  |
| **Statement to be Mailed?** | YES |
| **CoPay OR CoInsurance Amount\***  *Due Each Session* |  |
| **OR Deductible Amount Owed\***  *Client will be charged the insurance Carrier Reimbursement Rate until their deductible is satisfied. Client may pay this amount or arrange a Payment Plan* |  |
| **Approximate Number of Sessions Until Deductible is Met**  *This amount is based on the Carrier Reimbursement Rate times the number of sessions it will take to MEET the deductible. This does not include any medical expenses outside Sollars and Associates, but helps the therapist determine when to switch to charging the copay amount instead of the reimbursement rate.* ***The Billing Dept will alert the therapist via their DAILY LOG when the client meets his or her deductible. The therapist should contact billing by the date they expect the deductible to be satisfied to confirm.*** *\*****NOTE EXPECTED DATE ON YOUR CLIENT LIST*** |  |
| **Payment Plan Amount**  *Client made arrangements to pay therapist this amount until their deductible is satisfied. Client will have a remaining balance, which is the difference between the Payment Plan Amount and the Carrier Reimbursement Rate. CLIENT MUST MAKE A PAYMENT AT THE TIME OF EACH SESSION IN ORDER TO HAVE A PAYMENT PLAN IN PLACE* |  |
| **Method of Payment**  ***Client may choose to change their method of payment at any time***  *Available options include:*   * Cash in session * Check (Made payable to Sollars and Associates) in session * PayPal payment using client’s PayPal account OR Credit Card payment made through PayPal via Sollars’ website ***(Client does not need a PayPal account to use this option).*** They can type in their credit card information at time of payment   ***\*Cancellation fees must be paid prior to your next session*** |  |

*\*All insurance deductible and copay information was provided by the client’s insurance company and is subject to change. The client is ultimately responsible for all fees not covered by their insurance plan. Sollars and Associates anticipates your rate will be the amount calculated above, however rates do fluctuate based on insurance company charges and amount of time spent in session.*

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| --- |
| I authorize any clinical or other information needed for my insurance claim according to insurance policy requirements, and necessary to process as needed for billing purposes. I authorize any information needed for accounting and billing purposes. I also accept responsibility for payment of cash fees, co-pays, deductibles and non-payment of fees not paid to the provider by the insurance company. As is customary, I agree to pay my cash fee, deductible and co-payment at the time services are rendered. If no insurance coverage, I agree to pay my fee in full at each session. **There will be a $35 fee for returned checks.** |

|  |  |
| --- | --- |
| Client Printed Name |  |
| Client Signature |  |
| Therapist Signature |  |
| Date |  |

**INSTRUCTIONS FOR USE**

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| --- |
| *See YouTube tutorial for full instructions here:* [*https://youtu.be/JHR1M0T8ZX8*](https://youtu.be/JHR1M0T8ZX8)  *Please locate a blank copy of this form in the Admin office and fill in each section by hand prior to the intake. You will need to discuss any out of pocket costs with your client prior to the intake session and determine how they would like to pay these fees (Cash, Check or PayPal / Credit Card through the Sollars’ website (view the “Therapist’s Handbook” for more details on using the PayPal method). Inform clients their out of pocket fees are to be paid the same day of service. Please have your client sign and date this form during the intake. Make copies of their insurance card and driver’s license, front and back and write the client’s name on both copies. Immediately after the intake, fax this form and the copies of the cards to the Billing Department at 586-598-9641. Wait for the fax confirmation and staple it to these forms. Stamp this Insurance form with the “Faxed” stamp and date and initial. Place these forms in your blue mail folder at the location where you see the client. Please contact Admin via email if you have any questions. Thank you.* |